May 23, 2001

Mr. Mike Mangano
Acting Inspector General
Office of Inspector General
Department of Health and Human Services
Cohen Building
330 Independence Avenue, S.W.
Washington, D.C.

Dear Acting Inspector General Mangano:

The American College of Physicians−American Society of Internal Medicine (ACP−ASIM), representing over 115,000 physicians who practice internal medicine and medical students, is pleased to provide comments on your office's recently released report on *Improper Fiscal Year 2000 Medicare Fee-For-Service Payments* (FY 2000 Report).

We are pleased to note that the improper payment rate calculated by the Office of Inspector General (OIG) has reached its lowest level since this annual audit of the Health Care Financing Administration (HCFA) was initiated in Fiscal Year (FY) 1996, with the $11.9 billion figure for FY 2000 nearly half the $23.2 billion calculated for FY 1996. We believe this an indication that providers are committed to submitting accurate and adequately documented claims, and that such improvements depend on receiving clear and consistent information from Medicare's fiscal intermediaries and carriers. This is especially important for physicians in an era when Medicare's rules and requirements are forever changing, as exemplified by HCFA's still evolving evaluation and management documentation requirements, and the myriad local medical review policies which differ widely from carrier to carrier. While HCFA's efforts to improve communications between its carriers and the physician community have made some inroads, there is still much room for progress in this area.

Methodologically, we are disappointed OIG's FY 2000 report did not reflect needed improvements identified in our analysis of OIG's FY 1999 report, provided in our letter of March 24, 2000, as well as in person to Mr. Joseph Vengrin of your staff on April 5, 2000. Specifically, ACP−ASIM believes the following technical weaknesses in the design, execution, and interpretation of data in the FY 2000 report continue to undermine its credibility as a true indicator of improper payment rates, and likely overstates the actual number of claims paid in error.

1. <u>*Sample Size*</u>

Considering the high visibility of this annual report on Medicare claims payment error rates, we are concerned that such a small claims universe, only 5234 claims valued at $5.3 million dollars and representing only 610 Medicare beneficiaries (out of 39.5 million), is used to extrapolate an overall Medicare claims payment error rate, and that even smaller subsets of this 5234 claims universe are used to extrapolate error rates for the five provider types included in the report. This small sample is contrasted against a total FY 2000 claims universe of approximately 1

billion claims valued in the vicinity of $173.6 billion. The amount of statistical variation associated with such a small sample size was sufficient for OIG to add a disclaimer in its report stating that, although there was a $1.6 billion decrease in the total FY 2000 estimated Medicare fee-for-service error rate over FY 1999, "…we cannot conclude that this year's estimate is statistically different…The decrease this year may be due to sampling variability; that is, selecting different claims with different dollar values and errors will inevitably produce a different estimate of improper payments."

This does not inspire a great deal of confidence in the OIG's payment error estimates. In fact, the FY 2000 report acknowledges that the actual error rate, at the 95% confidence level, could be anywhere from $7.5 billion to $16.2 billion, rather than the $11.9 billion reported as the midpoint in this exceptionally wide range of plus or minus 36.5 percent.

Recommendation: ACP–ASIM continues to urge OIG to substantially increase overall and provider-specific claims sample sizes to lend greater credibility to its payment error estimates.

2. *Reliance on Carrier Review Staff*

ACP–ASIM continues to be concerned over OIG's reliance on Medicare claims payment contractors to determine claims payment error rates. The United States Government Accounting Office (GAO) released two reports in July 1999 documenting serious flaws in the performance and integrity of several of these contractors, including improperly screening, processing, and paying claims, in order to inflate their Contractor Performance Evaluation scores presented to HCFA. The GAO's findings were further supported by OIG Deputy Inspector General George Grob, who in July 1999 presented the following congressional testimony detailing fraudulent conduct of some Medicare contractors:

"Of all the problems we have observed, perhaps the most troubling has to do with contractors' own integrity—misusing government funds and actively trying to conceal their actions, altering documents and falsifying statements that specific work was performed. In some cases, contractors prepared bogus documents to falsely demonstrate superior performance for which Medicare rewarded them with bonuses and additional contracts. In other examples, contractors adjusted their claims processing so that system edits designed to prevent inappropriate payments were turned off, resulting in misspent Medicare Trust Fund dollars. The examples I describe are not isolated cases. At any given time, several contractors may be under investigation by our office. To date, our investigations have resulted in 9 civil settlements and 2 criminal convictions, and we currently have 21 former or current contractors actively under investigation."

Though Mr. Grob's testimony makes it clear that the performance and conduct of a large number of Medicare claims payment contractors cannot be trusted, OIG has staked the credibility of its FY 2000 Medicare error payment rate estimates, in large part, on a small subset of these contractors.

Recommendation: OIG should provide in its report written reassurance that those contractors used by OIG in calculating the FY 2000 error rates have clean performance track records, and are not among the 32 considered suspect by OIG, as noted above.

3. *Physician Coding Errors*

Concerning physician coding error rates, the OIG report indicates little change in this category for the five years OIG has issued its Medicare claims payment error report. We suspect that a sizeable proportion of physician coding errors are related to which Evaluation and Management (E/M) intensity level is selected.

A study conducted by the OIG in 1995 suggests that coding for E/M services is largely subjective. The OIG asked eight Medicare carriers to use the E/M codes to code five different hypothetical patient office visits. The report states that "none of the five vignettes were coded in the same way by all sampled carriers, which illustrates carrier difficulty in understanding the visit codes."

Recommendation: Given the wide variations in carrier interpretation of codes for E/M services, ACP-ASIM believes that it is misleading to conclude that a one-level difference of opinion between a carrier reviewer, and the physician who submitted the bill, constitutes an improper payment. In the future, we would urge OIG to not count a disagreement over one E/M level as an error, but rather place it in the domain of reasonable professional differences in judgment. At the very least, providing a detailed breakdown of coding level differences, including undercoding, showing whether the OIG reviewer found the E/M level one level too high, one level too low, etc. would be make the information provided in this error category much more useful educationally to physicians.

4. *Medically Unnecessary Services*

The FY 2000 report notes that "Medically unnecessary services were a significant problem for the 5-year period" that Medicare payment error rates have been calculated by OIG, representing 43 percent of the $11.9 billion total error rate for FY 2000. Of this, about 11.8 percent or $0.6 billion was attributed to physicians. Unfortunately, only one example is given related to physicians, making it impossible for physician readers to
learn what made up the $0.6 billion in claims judged as medically unnecessary.

Recommendation: ACP–ASIM urges OIG to provide a categorical breakdown of why claims failed to meet Medicare medical necessity requirements, for the educational benefit of the various provider groups reading the annual OIG report.

5. *Unsupported Services*

Though this error category's magnitude has shrunken substantially for physicians from a high of $3.2 billion to an average of only $0.6 billion over the last two years, we note that OIG continues to count as errant claims for which documentation requests to physicians were not answered. ACP–ASIM believes the OIG's decision to count such claims as errant, even though the actual

medical record may fully support services billed, results in an unfair distortion and overstatement of the “unsupported services” error rate.

Recommendation: ACP–ASIM believes that OIG should not count claims for which documentation requests are not received as “unsupported services.” Rather, the source medical record should be considered the ultimate determinant of whether services rendered to a patient are adequately justified. With such a small sample volume, it might be prudent for OIG to request documentation from a wider universe of physicians, since any survey will have a certain number of non-respondents due to disinterest or administrative burden, which in no way bears on whether services provided are supported by the medical record.

6. *ACP–ASIM Comments on OIG’s Recommendations to HCFA*

In its FY 2000 report, OIG recommends that HCFA direct its carriers to expand physician training, emphasizing the importance of documentation. Though ACP-ASIM agrees that documentation can be improved, we are concerned that the practical result of the OIG’s findings will be the imposition of rigid and overly burdensome documentation requirements by HCFA and its carriers. At present, HCFA still has not decided on the “framework” for documentation of E/M codes. Nor has it agreed on the timing and methodology that will be used to pilot test alternative methods of documenting E/M codes—despite having made a commitment to conducting a pilot test before a decision is made on the required level of documentation. Consequently, it will be difficult to educate physicians on documentation of E/M services when there is still no agreed upon framework for documentation.

The OIG further recommends that HCFA refine Medicare regulations to enhance the probability that services are correctly coded and sufficiently documented. ACP-ASIM is concerned that this recommendation could lead to imposition of more prepayment screens, “black box” coding edits, delays in processing claims, and overly burdensome documentation requirements on physicians.

Recommendations: ACP–ASIM urges OIG to advocate for HCFA adoption of a number of recommendations contained in the Medicare Payment Advisory Commission’s (MedPAC) 2000 report to Congress. Specifically, MedPAC recommended that:

(1) “HCFA should continue to work with the medical community in developing guidelines for evaluation and management services, minimizing their complexity, and exploring alternative approaches to promote accurate coding for these services.”

(2) HCFA “should pilot-test documentation guidelines” and “continue to work with the medical community in developing the pilot tests, and should ensure adequate time for physician education.”

(3) HCFA “should disclose coding edits to physicians and should seek review of the appropriateness of those edits by the medical community.”

(4) HCFA should "monitor changes in coding patterns that may have resulted from intensified Medicare review, including the possibility that inappropriate downcoding of services may be taking place."

Summary

The credibility of OIG's annual estimate of Medicare claims error rates would greatly be strengthened by utilizing larger claims samples and by assuring that the Medicare contractors employed by OIG to review claims in the sample have proven performance track records and a high level of professional integrity. We recommend not counting one level differences in E/M codes as errors, since professional judgment and subjectivity play a large role in determining what E/M level is appropriate. We further recommend that OIG not automatically count as errant claims for which documentation requests are unfulfilled.

It is important that MedPAC's recommendations to HCFA be aggressively pursued, to provide physicians with greater clarity and precision on coding and documentation requirements, supported and reinforced with training and an open, didactic carrier review process, and a new emphasis on avoiding inappropriate downcoding of services. Lastly, we would urge OIG advocate HCFA's release of E/M pre-payment review data for the educational benefit of the physician community.

ACP−ASIM has enjoyed a very positive collaborative relationship with OIG since we began meeting regularly with your staff in May of 1999. The credibility and value of the annual Medicare improper payments report would be greatly enhanced if the technical suggestions we provided a year ago, and repeated above in this letter, could be incorporated into next year's report's design, execution, and method of interpreting findings. We would be glad to meet with your staff in the near future to discuss our suggestions further, with the goal of making the FY 2001 report more not just a scorecard, but also an instructive and educational tool from which all physicians can learn.

Sincerely,

Robert B. Doherty, Senior Vice President
Governmental Affairs and Public Policy